SMITH (A.L.)

Ventrofixation and Alexander's Operation Compared

BY

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VENTROFIXATION AND ALEXANDER'S OPERATION COMPARED.[1]

Comparatively limited as my experience has been with these two operations, yet it might be of interest to the Society to give that experience and the conclusions which I have drawn from having performed one or the other of them forty-nine times.

I need not take up the time of such learned men as these around me in pointing out the necessity for this or any operation for the cure of retroversion. When I say that I have only performed the Alexander operation twenty-one times and ventrofixation twenty-eight times in the last five years, while during that time I must have attended many hundred cases of this disease, it is evident that I only considered a small number of them as being subjects for operative treatment. Many cases have come before my notice in which the retroversion was discovered incidentally and caused no symptoms whatever. Others, suffering from slight symptoms, were easily cured, simply by replacing the displaced organ and by removing the cause which brought the condition about. Others, again, failed to be cured by such simple measures and required the prolonged use of the tampon, and others of the pessary. It was only in those cases which were not benefited by these means that I resorted to the operation. If there are those who doubt the necessity of treating this condition at all, as I believe there are a few, let me remind them that a woman with retroversion sometimes suffers so acutely and constantly as to be really an object of pity. Not only is the circulation of the uterus greatly interfered with by the kinking of the vessels in the broad ligaments and by the pressure of the fundus on the uterine veins, but also the bladder is frequently irritated by the pressure of the cervix on its neck, and the bowel also by the pressure of the heavy fundus on the rectum, which is in some cases sufficient to completely obstruct all passage through the bowel, the patient constantly experienc-

[1] Read before the American Gynecological Society at the meeting in Baltimore, May 28th, 1895.

ing a feeling of tenesmus or bearing down, the obstacle to defecation being present even when the bowels are in a liquid condition. But the worst symptoms, perhaps, are the reflex ones caused by the pressure of the uterus on the branches of the great sympathetic nerve, leading to distention and sluggishness of the bowels, dyspepsia, palpitation of the heart, disorders of vision, and headaches. Neither must we forget that the retroverted uterus and ovaries are often so painful as to offer an insurmountable barrier to sexual intercourse.

Of the many claims to our gratitude which Dr. Howard Kelly has won I think this the greatest, for of all the operations which I have ever performed the one which has afforded me the greatest satisfaction is ventrofixation of the uterus. The satisfaction comes from three distinct sources: first, from its effectiveness in accomplishing the object desired; second, in accomplishing it with the smallest possible risk to the patient; and, third, in effecting it with the greatest possible ease to the operator.

I shall now consider each of these points in detail. First, its efficiency. When a woman consults us for retroversion of the uterus, for prolapse, or even for procidentia—using this term to mean falling of the womb in which the organ projects more or less from the vulva—we may treat her in several different ways. We may advise her to wear a tight T or perineal bandage; this of course is the poorest kind of a makeshift and one which few women would be content with. We may replace it and keep it up by means of cotton or woollen pads, which are, however, very unsatisfactory for the reason that the vulva in many cases is large and relaxed; the tampon will only remain in for a short time, dropping out either while she is walking or at the next effort at defecation. Even if the tampon, when accompanied by the perineal pad which keeps the tampon in, were effective, there would still be the great objection that its use necessitated the spending of much of the unhappy woman's time in journeying to and fro to the dispensary or consulting room. This method never cures, and the patient sooner or later becomes tired of it and abandons it altogether. The next best treatment is the pessary, but this has been abandoned by most specialists, although practised still by some general practitioners. The pessary has many objections. First of all, if the ovaries and tubes are inflamed and bound down by adhesions the pessary cannot be borne, and as a rule the patient returns in a few hours or in

a few days, stating that she cannot bear the pain of it, and she will with good reason blame us for making her worse. Second, even if there were no inflammation or adhesions and the uterus and appendages were freely movable, the vaginal outlet, as a rule, is too large to prevent the pessary from coming out, or, if not already so, the pressure exercised by the pessary will distend it until it drops out, and then larger and larger ones must be introduced. Even when the vulva is small, as in virgins, and the pessary can be worn by the patient, she must come at regular intervals to the physician's office to have it cleansed and reintroduced; it is more or less a constant source of irritation and is apt to cause leucorrhea, which in many cases I have seen become purulent; in other cases it becomes encrusted with phosphatic deposits, rendering it exceedingly irritating; cases are even on record in which the pessary, when not regularly attended to, has ulcerated through the vaginal wall until malignant disease has been set up, and in other cases it has worked its way clear through the vagina to the abdominal cavity, whence it has been removed by abdominal section. Third, the pessary interferes more or less with sexual intercourse, while most women feel uncomfortable at the very idea of having an instrument inside of them and are always glad to dispense with it as soon as possible. To give the pessary its due, however, we must admit that a few cases of retroversion and prolapse are cured after three months' to a year's use of it, but in the meantime, of course, the uterus comes down again when the pessary is removed. It is most useful in temporary cases, such as when the womb falls because it has become pregnant and heavy; in such cases the pessary is useful to hold the womb up until the end of the third month, after which by its size it will be prevented from falling backward or descending. One of the objections to the pessary can be remedied by reducing the size of the vaginal outlet by performing anterior and posterior colporrhaphy, or, in other words, sewing up the lacerated perineum and reducing the area of the anterior vaginal wall by means of Stoltz's operation. Some have thought to cure the prolapse by this operation alone, but now all operators agree, especially Martin of Berlin, that no matter how much the vagina may be narrowed, even to the extent of closing it up altogether, as by Lefort's operation—which, of course, is only applicable to old widows—the uterus will still come down and present at the vulva. By at the same

time dilating, curetting, and repairing a lacerated cervix, or amputating it if there is much cystic disease, the weight of the organ is reduced so much that the weak and relaxed ligaments are sometimes able to hold it up, but more often it drops again in spite of everything.

There remain three other procedures which are effective and which I shall mention in the order of their gravity—first, removal of the uterus by the abdomen or by the vagina; second, Alexander's operation; and, third, ventrofixation.

Although the removal of the retroverted or prolapsed uterus by the vagina is a much safer operation than when it is performed for a cancer or fibroids, owing to the facility with which it may be brought down and all bleeding points seen and secured, and also to the greater certainty of accomplishing asepsis, yet we are hardly justified in resorting to it or to any operation in which the danger is so much greater than is the simple fastening of the uterus to the abdominal wall; while, when the appendages are diseased and the uterus is firmly attached with them to the sacrum or rectum, I have no hesitation in saying that the abdominal route is much more rational than the vaginal one. Even the authors of the latter method—Ségond, Richelot, and Péan—admit that they are frequently obliged to leave portions of the diseased structures adherent to the intestines. But even when there are no adhesions, is removal of the uterus and appendages always effective for curing prolapse of the pelvic contents? True, the uterus when removed can no longer prolapse, but the uterus is not the only organ there; even after its removal the woman may have prolapse of the pelvic floor, unless care is taken to sew the broad ligaments together, which is seldom done, although for my own part I make a practice of doing so when I remove the entire uterus by the vagina. But with ventrofixation not only is the entire uterus preserved and held up, but also the bladder, vagina, and small intestines are equally supported.

When we compare ventrofixation with Alexander's operation as regards efficiency, ventrofixation has one great advantage. Alexander's operation is a complete failure in all cases in which the uterus, or even the ovaries and tubes, are adherent. True, Alexander's operation was never meant for such cases, and no one would knowingly do it when the uterus is fixed. But sometimes the uterus appears movable and yet the mobility is very limited, and when we attempt to draw the fundus up to the

abdominal wall by means of the round ligaments the latter will break sooner than the adhesions will. These adhesions which anchor the uterus explain some of the frequent failures of Alexander's operation; when there were no adhesions I have found Alexander's operation very effective in holding up the uterus. I have never had hernia after it, and I have only known of one relapse out of twenty-one cases.

One objection to Alexander's operation is that the round muscles, when they have not contracted for a long time, become fatty and break when pulled upon. There is another objection to Alexander's operation which does not apply to ventrofixation, and that is the pain and numbness of the groins and labia due to the severing of the nerve running along the round ligaments, of which several of my patients have complained.

Now, if we look at the two operations of ventrofixation and Alexander's from the standpoint of the risk to the patient, one might think at first sight that in this one respect, at least, the odds were in favor of Alexander's operation. But this is not the case. If there are no adhesions of the uterus, and the ovaries and tubes are not attached, the mere opening of the abdomen and fixation of the uterus under the rigorous aseptic precautions which we now employ is absolutely devoid of danger; while if there are adhesions it is ever so much safer to detach them with the fingers in the abdomen than to replace the uterus with the sound. At least one case has come to my knowledge of death from this procedure. Neither is Alexander's operation entirely devoid of risk, if not to the patient's life, at least to her comfort. A number of cases have come to my knowledge in which single or double inguinal hernia has followed—this, of course, should never happen, but the fact remains that it has happened; and a great many cases have been followed by suppuration, this having occurred in one of my own cases, while in a case under the care of a colleague the suppuration spread down between the folds of the broad ligaments, causing a true pelvic abscess. A few cases of death even have been recorded as having followed Alexander's operation; but it is only fair to say that since writing this paper I have heard of a case of death in Baltimore following ventrofixation from bleeding from the needleholes into the uterus, although I cannot understand how that accident could have happened. It must be distinctly understood that when ventrofixation is performed for removal of pus tubes or tearing away

of adherent ovaries, it then assumes the mortality of the larger operation, which is greater or less according to who the operator is.

When we compare the operation from the point of view of the ease with which it can be performed, Alexander's operation is *hors de combat*. I was so fortunate at first in quickly finding the round ligaments and drawing them out that I could hardly believe that any skilled operator could have any difficulty in doing so; but after coming across two or three cases in succession in which the ligament broke on the slightest traction, I was compelled to open the abdomen and complete the Alexander operation by doing ventrofixation. I have also spent as much as one hour in finding the two ligaments, and I have seen other operators spend even more time and yet fail to get the uterus forward, the incision having to be closed without curing the retroversion. I have, indeed, heard one quite well-known surgeon say, after searching for the ligaments for one hour and a half in vain, that he had tried it for the last time.

If the uterus were always free from adhesions when it appears so, and the round muscles always healthy, red, fleshy, and fairly strong bodies, there would be no difficulty in finding them and drawing them out. But, as a rule, in chronic cases of retroversion the muscle has not contracted for weeks, months, or years; the inevitable result is, of course, fatty degeneration. Ventrofixation, on the contrary, I have always found extremely easy. It can frequently be performed in from ten to fifteen minutes with an expenditure of less than an ounce of A. C. E. mixture. There is never any doubt about finding the uterus, and, when found, never any difficulty about drawing it up; when performed in the Trendelenburg posture it affords us an opportunity of examining the tubes and ovaries and of repairing them when necessary.

I cannot reconcile myself to the belief that so serious a mutilation as total extirpation for retroversion or prolapse is justifiable when such serious results may be avoided by the operation which I have just pointed out. My own course has been, when the case requires it, to perform, first, rapid dilatation; second, curetting, with the application of pure carbolic acid and tincture of iodine to every part of the endometrium; third, repair of the lacerated cervix; fourth, closure or narrowing of the anterior and posterior vaginal wall; fifth, opening the abdomen and libe-

rating the uterus from its adhesion, and at the same time removing the appendages or as much of them as are diseased; and, sixth, fastening the uterus to the abdominal wall—all of which can be done in a little over an hour. My results in such cases, as I stated at the outset, have been most gratifying.

The objection is sometimes made that the uterus is a movable organ and should not be fixed in an immovable position. While this may be admitted, I am in a position to state that ventrofixation does not put the uterus in an immovable position, for in the one and only case of failure, which a year later necessitated my reopening the abdomen, I had an opportunity to see that the uterus was hanging by a cord as thick as a lead pencil, extending exactly from the place where I had fastened it behind the pubis to the anterior surface of the uterus. In many cases, on examining the patient with the Sims speculum I could see the normal amount of to-and-fro movement of the organ taking place. The union allows free movement to the uterus and in no way interferes with pregnancy.

Just a few words now as to the method of operating. After the usual aseptic precautions a small opening is made in the abdomen, about one and a half or two inches being sufficient to admit two fingers, with which the uterus is lifted up, the adhesions torn away, if there are any, and the ovaries and tubes examined. While held up by the fingers the fundus is caught by the bullet forceps just in the centre and held in the incision, while a space of a square inch is scarified with the point of the scalpel. It is then lowered for a moment while the corresponding surface of the abdominal peritoneum is treated in the same manner, thus insuring broad and strong adhering surfaces. It is then drawn up again, while two well-sterilized silk ligatures are passed through the fascia, then through the anterior wall of the uterus, and then through the fascia of the other side, tied and cut short to be left in permanently. In two cases I used silkworm gut for this purpose, but this caused trouble and I abandoned it; in more than half the cases I did not leave any permanent ligatures in, and it was in one of these that the failure occurred. The abdominal wall is then closed according to the taste of the operator, my preference being given to the through-and-through silkworm-gut sutures, which I invariably leave in one month, by which time the exudation tissue has formed and has become thoroughly organized and strong.

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